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MEDICAID AND AFDC FRAUD AND ABUSE CONTROL

AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

"BEST PRACTICES" CASE STUDY: MASSACHUSETTS MEDICAID PROGRAM

October 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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MEDICAID BUREAU

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"Best Practices" Case Study

Massachusetts Medicaid Program

A Descriptive Review of Exemplary Program Options

Prepared Under SRS Contract No. SRS-500-75-0004

by

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October 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Medicaid Bureau

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PREFACE

This report is one of a series of "best practices" case studies prepared by General Research Corporation and its subcontractor SysteMetrics under contract to the Office of Planning, Analysis and Evaluation, Social and Rehabilitation Service, Department of Health, Education and Welfare. These case studies are part of a larger effort by General Research Corporation and its subcontractor SysteMetrics to assist DHEW in the analysis of the fraud and abuse control activities nationwide in Medicaid and Aid to Families with Dependent Children programs. Other activities include a nationwide mail survey to collect baseline data on fraud and abuse control efforts in all states and an analysis of the options available to the Federal government to further enhance fraud and abuse control in these programs.

The "best practices" case studies are based on visits made by GRC/SysteMetrics staff to selected states which appeared to constitute the best examples of fraud and abuse control programs. The primary objective of this effort is to determine what procedures and practices that the selected states are using appear to be effective and worthy of replication in other jurisdictions. Each state is individually reported in this case study format and from this data base a final analytic report discussing the relative value of the exemplary practices seen in all states will be prepared. The states to be reported in this series include:

Medicaid	AFDC
California	Maryland
Maryland	Massachusetts
Massachusetts	Michigan
Michigan	Minnesota
New Jersey	New Jersey
Ohio	Ohio
Oklahoma	Pennsylvania
Pennsylvania	Washington
Washington	Wisconsin

The states were selected in conjunction with DHEW personnel and represent those states which appeared to represent a mix of practices of interest to the study and which were suitable for site visits at the time of the study. Therefore, these do not necessarily represent the "best" nine states with respect to fraud and abuse control in each program but are certainly among the best.

Fraud and abuse control is an integral part of maintaining program integrity and increasing the quality and efficiency with which the program is administered and program goals are achieved. It is essential that fraud and abuse control procedures not be viewed in isolation from other program elements, but should be recognized as being part of a series of steps which states can take to improve the operation of their programs and reduce costs incurred through the misappropriation of program funds. Therefore, in the course of conducting this study and in developing the case study reports, fraud and abuse control efforts have been defined to include all systems and procedures which impact fraud and abuse prevention, detection, investigation, administrative actions, prosecutions and recovery. The case studies are organized to report each state's activities in these functional areas in the initial chapters. The authors' opinions and analysis have been reserved for the final chapter on best practices. The best practices chapter is designed to discuss conceptually how and why procedures reported in the initial chapters are exemplary and may be suitable for replication in other jurisdictions. Therefore, the best practices chapter discusses the pros and cons of such practices in various settings and is not directly a comment on the state reported, but rather an analysis of the practice per se and how the reported state exemplifies the concept.

Finally, these reports are in no way intended to be evaluations of the states involved and General Research Corporation is deeply indebted to the states which so graciously participated and assisted in these studies through the contribution of their time, information, and ideas.

ACKNOWLEDGMENTS

General Research Corporation and the author wish to extend our sincerest thanks to the staff of the Department of Public Welfare and the Bureau of Welfare Auditing, particularly Mr. Toby Choate, Mr. Paul Taylor, and Mr. Raymond Jowdy who on several occasions shared their time to assist in this study. The ideas and commentary provided by these individuals have significantly aided in the study effort beyond the scope of this individual report.

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MASSACHUSETTS MEDICAID CASE STUDY

I. PROGRAM OVERVIEW

A. Introduction

The Massachusetts Medicaid program is administered by the Massachusetts Department of Public Welfare (DPW). However, fraud and abuse control in the state is the responsibility of both the DPW and an independent agency established in 1972. The independent agency, the Bureau of Welfare Auditing, developed from the Fraudulent Claims Board, which was made a part of the DPW in 1968. The Board was reconstituted in 1972 and the Bureau of Welfare Auditing (BWA) was established as its staff arm. Within the DPW, another agency is also responsible solely for Medicaid fraud and abuse. This is the Office of Sanctions of the Provider Review Unit, which is within the Medical Assistance Division. The Office of Sanctions was established in March 1974 to implement the fraud and abuse control sections of the State Plan.

Both the Office of Sanctions and the Bureau of Welfare Auditing have experienced significant changes in the last year due to the increased emphasis on fraud and abuse control and the presence of the Federal Review Team. The functions and relationships of the two offices and the changes which have taken place are discussed in the context of program administration and operations in subsequent sections of this report.

Massachusetts was the first state to participate in the Federal Review team process and the assignment of the team was announced by Secretary Matthews on March 28, 1976. The protocol team began work in Massachusetts in April. Data for this report was collected in mid-July 1976 while both the Federal Review Team and the state were beginning their review. At that time Massachusetts had laid the ground work to continue to make significant strides in the fraud and abuse control area.

B. Program Characteristics

The Medicaid program in Massachusetts includes both the categorically and medically needy and is administered by the Department of Public Welfare (DPW), as stated above. Approximately 20,000 providers participate in the program. About half of these are physicians.

A major influence on the program is the serious financial constraints under which it and the entire state government operate. As an example, in the spring of 1976, DPW was forced to reduce the fee schedule for physicians by 30%.

C. Overview of Administration

Exhibit I-1 presents an organization chart for the Department of Public Welfare. The Department centralized its internal fraud and abuse control efforts in the Medical Assistance Division Provider Review Unit in early 1976. The Medical Assistance Division program offices for each category of service are responsible for policy guidance and regulation. These program offices assist Review Unit and its Office of Sanctions through referrals and assistance in reviewing particular providers, as appropriate.

Claims Processing

Historically, claims have been processed by one of three agencies.

- Pilgrim Health Applications - a private contractor which processes dental, laboratory and pharmacy claims.
- Blue Cross/Blue Shield - contracts with the state to process all medicaid claims which are tied to medicare for which BC/BS is the carrier in the state.
- Medical Claims Control Center at Westboro, Mass. - the DPW computer center which processes all other claims.

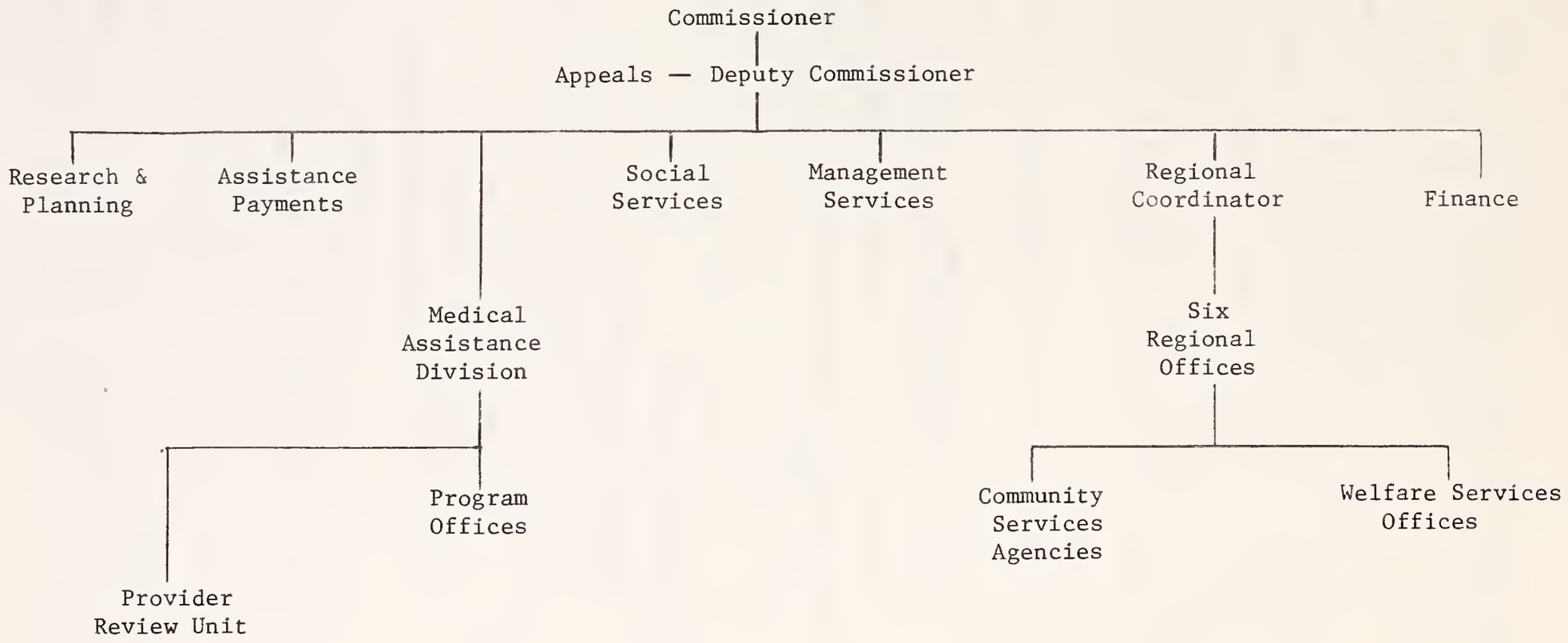
Providers submit their claims directly to the appropriate claims processing organization.

For some period of time DPW has not been satisfied with the quality of the claims processing systems at the Westboro Center. The contract with Pilgrim Health Applications represented the first step away from the existing system at Westboro.

Exhibit I-1

ORGANIZATION CHART

MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE



At the time of the data collection visit, DPW was in the process of procuring a contractor for installation of the MMIS. Since the existing claims processing capability is of relatively little assistance to fraud and abuse control, does not constitute a best practice, and is familiar to the Federal Review Team, it will not be further addressed in this report.

The regional office structure within the DPW is important to its functioning. The operational structure for the Income Maintenance and Social Services programs on the regional level is composed of the Regional Coordinator, regional offices and Community and Welfare Services agencies. Among their other duties, staff in local offices are responsible for determining eligibility for medically needy recipients. For details on the operations of the Regional Coordinators Office and the services agencies see GRC's report on AFDC recipient fraud in Massachusetts.

There are three state agencies outside of DPW which work with the Provider Review Unit.

Bureau of Welfare Auditing

BWA is the most important of the non-DPW agencies. Established in 1972 as the staff arm of the Fraudulent Claims Commission, it is responsible for investigating all types of welfare fraud in the state. All provider cases which exceed "program abuse" and involve suspected fraud are referred from DPW/Provider Review to BWA. In addition, BWA is responsible for investigating recipient and agency fraud cases. BWA is further discussed in the investigation section of this report.

Rate Setting Commission

This independent agency is responsible for all state rate setting and auditing. Analysis and investigation of institutional costs under the Medicaid program is the responsibility of this agency.

Board of Registry

This agency is responsible for licensing providers and providing information to DPW on the status of providers within the state.

In summary, the two key offices with respect to fraud and abuse control within the state are DPW/Provider Review Unit and the Bureau of Welfare Auditing.

II. PROVIDER FRAUD AND ABUSE CONTROL PROGRAM

A. Administration

The original Office of Sanctions was established in March 1974 and until 1976 was essentially a one- or two-man operation. During this period

the Sanctions officers were limited to pursuing only the most blatant cases and using simple techniques for identification of cases such as high-dollar providers. However, this unit logged a number of suspensions and collected approximately $360,000 in restitution over a one-and-a half-year period.

In early 1976, the Office of Sanctions was incorporated into a new Provider Review Unit. The staffing level for Provider Review is 23 professionals and five clerks. This increased staffing level has allowed for substantial expansion of activities in prevention, detection, investigation and pursuit of program abuses which will be discussed in subsequent sections.

The Provider Review Unit is divided into five functional areas under the unit director. These areas are:

- Sanctions, responsible for detecting, investigating and pursuing abuses of the program by providers;
- Provider Review, responsible for implementing the new provider review program described in the detection section of this report;
- Provider Application, responsible for completely verifying a provider's eligibility status and compliance with the conditions of participation prior to the issuance of a provider number;
- Policy development;
- Support, the office manager and clerical staff.

The Bureau of Welfare Auditing (BWA) was established outside the DPW by the Legislature in 1972, largely in response to concern for welfare recipients' fraud. It is the staff arm of the Fraudulent Claims Commission, which was created by the Legislature as an independent commission reporting to the Governor. The Commission is comprised of the Secretary of Finance and Administration, the Attorney-General, and the Commissioner of DPW. As the staff arm of the Commission, the BWA administratively reports to the Secretary of Finance and Administration.

The BWA has approximately 60 staff members located in the headquarters office in Boston and six regional offices. The budget is approximately $730,000 per year, of which approximately 50% is provided through Federal Title IV and XIX matching funds.

BWA is staffed almost entirely with "investigators" with backgrounds in police or other investigative agencies. This office's only responsibility is to investigate potential cases of prosecutable fraud and refer apparently prosecutable cases to the appropriate prosecution agency.

Until the last year, BWA was largely responsive to the issue for which it was created — recipient fraud. Now, however, approximately half the staff's time is spent on Medicaid provider cases, although these constitute only 2% of the total caseload. The major sources of BWA cases are referrals from the Provider Review Unit at DPW.

B. Prevention

To date prevention has not been a systematized process except to the extent that the administrative sanctions procedures and prosecutions served as deterrents. Both the Provider Review Unit and BWA argue that administrative penalties and prosecution, when used appropriately, are excellent prevention techniques. However, there are two areas in which the state is improving its prevention capability.

- Provider Review is thoroughly checking licensure status with the Board of Registry prior to the issuance of a provider number. This is to correct prior deficiencies in the issuance of provider numbers and to assure recordation of specialities in which the provider is qualified to practice.
- The state is proceeding to implement the MMIS. Current claims processing systems do not have the prepayment edit and suspension capabilities of the MMIS.

An additional technique which has aspects of prevention is prior authorization. Prior authorizations are required for a range of services and are authorized by medical assistance staff. The shortage of manpower to perform this task, the length of time required to get an authorization returned, and the lack of capability in the claims processing system to check for authorization have in the past hampered the effectiveness of the prior authorization system. For example, in one case a dentist had requested priors for dentures on all patients in a nursing home. When detected, this appeared to be a questionable practice and investigation by the dental consultant showed that some patients did not need dentures or already had them. In this case, the dentist said that it took so long to get authorizations that he had, in fact, requested priors on all patients even prior to examining some of them. He argued that by the time he got the authorizations he would

have determined which patients needed dentures and which did not; that he would not use the authorizations for those that did not, but that he would have authorizations for those who did and he could proceed with the work in a timely fashion. This anecdote is recounted because many states value the prior authorization system although little attention has been given to the system's effects and cost benefit.

C. Detection

Several fraud and abuse detection methods are in use by the Office of Santions of the Provider Review Unit, which has primary responsibility in this area. One of these is the scheduled review of a sample of providers by the Provider Review Unit. During FY77, 500 providers are scheduled for review. The review methodology is based on the method used by the Federal Review team as modified for state use. The sample to be reviewed will include:

200 physicians (45 were completed in June)
75 dentists
100 licensed medical practitioners
25 transportation providers
50 durable medical equipment suppliers
10 laboratories
40 clinics

Five-hundred pharmacy reviews have also been purchased from Pilgrim Health Applications and this review function will be assumed by the Provider Review Unit in subsequent years.

The reviews will be based on the available claims history data and output reports; field visits to providers offices; and discussions with recipients. There are 14 field reviewers and two managers to conduct this function.

While this provider review program will in part serve as a detection method, the unit emphasizes that it is geared to be a provider relations and education activity in which providers and DPW staff can work toward mutual goals of improving the Medicaid program, assuring quality care to recipients, and efficiency in paying providers of services. The staff sees this as an opportunity for providers to get feedback on ways to improve their billing

procedures, policy interpretations, etc., and for DPW staff to get feedback from providers on problems they see in the program and its administration. Therefore, staff emphasize that detection may be a by-product of this activity and is not its primary purpose. It must be noted that while the investigation/sanctions function is also located within the Provider Review Unit, it is in a separate unit and largely conducted by separate staff.

A second method of detection is the services verification program. Since September 1975 a small random sample of dental claims has been regularly selected and verified with recipients. Physician and pharmacy claims were expected to be added to this program in late summer 1976.

The Office of Sanctions within the Provider Review Unit also uses other tools to detect abuse and potential fraud. These tools include reports available from the claims processing system, review of high-dollar providers, and complaints. The implementation of the MMIS will greatly enhance the detection capability of Sanctions.

It should be noted that like many other states, Massachusetts has not had a satisfactory relationship with the Bureau of Health Insurance and, therefore, does not benefit from Medicare detections. While BHI may suggest a possible investigation to Sanctions, it will not share its rationale or any of its information. Since Sanctions does not know why BHI is investigating a particular provider, it feels that investigating a provider to find out why BHI thinks it should be investigating is a waste of resources.

D. Investigations

In Massachusetts "investigations" are conducted by either DPW/Provider Review/Office of Sanctions or the Bureau of Welfare Auditing, based on whether the case involves program abuse or alleged fraud.

Fraud Cases

Since Provider Review is the primary detection agency, most cases originate there. At the point at which a case appears to involve fraud, Sanctions opens discussions with the Bureau of Welfare Auditing concerning a referral. BWA may also receive complaints from other sources such as the public. This instance, too, would necessitate discussions between the two agencies. There can be three outcomes from these discussions:

— The allegation appears to be warranted; BWA takes the case; and Sanctions acts only in a supporting capacity to BWA such as supplying profiles, claims histories, etc.

— The allegation appears to be warranted; BWA takes the case; but agreement is reached for Sanctions to also continue to investigate the case for program abuse and possible administrative sanctions.

— For various reasons, BWA does not believe the case represents prosecutable fraud and, therefore, does not investigate the case. Sanctions may continue the investigation of program abuse, possibly leading to administrative sanctions.

Of course, these discussions and possible outcomes can occur at various points in the case flow. For example, Sanctions may spend several weeks or months investigating program abuse before it determines that a fraud case probably exists. Only at this point is discussion with BWA appropriate.

The critical criterion for acceptance of a case by BWA concerns whether the case is "actionable" or prosecutable fraud. BWA is primarily concerned with prosecutions; cases which on investigation appear to involve non-prosecutable abuse are referred to other agencies, such as DPW-Sanctions. To some extent, the prosecution potential of a case does depend on dollar size since that may be of key interest to the prosecuting attorney or judge and the key factor in their acceptance of a case. Nevertheless, BWA recently had a large dollar fraud prosecution thrown out of court because the judge said that he did not have time on the docket to try white-collar crime. In this case the prosecuting attorney had presented the case and was not the obstacle. Other factors which affect the prosecution potential and, therefore, BWA's judgment to pursue a case are the potential for proving intent the key element of a fraud charge, and jury appeal. BWA feels there is little point in investing resources in thoroughly investigating a case if a reasonable expectation of conviction does not exist. Lack of jury appeal and inability to gain convictions is a particular problem in cases involving very elderly or handicapped defendants toward whom a jury is likely to be sympathetic. BWA avoids these cases.

Once BWA has accepted a case, it is assigned to an investigator. Investigators have no police powers, but subpoena power is being sought for

the unit through legislative amendment. Investigations of provider fraud usually begin with a detailed desk review of the provider's claims based on either random selection or selection of those that appear to be involved in the fraud. Depending on the nature of the allegation, patients are identified, contacted and interviewed and affidavits taken as to whether the services were received, etc. Attached as Exhibit II-1 is a sample of a letter sent to recipients for whom claims were paid to an ambulance provider under investigation. The responses were screened and follow-up interviews were scheduled with recipients whose responses did not support the claims submitted by the provider. The investigator may also visit the provider's place of business to review medical records, prescriptions, laboratory reports, etc. and interview the provider. Witnesses may also be used. In one potential fraud case a typographical error in the regulations would have provided the provider a loophole for his billing practices. However, BWA investigators located witnesses who could testify that the provider was present at a meeting when the error was discussed and the correct procedure explained, prior to the time for which the fraudulent bills were submitted.

Each investigator's cases are reviewed at least monthly by a supervisor, and more frequently if warranted. The investigator and supervisor mutually agree as to the value of pursuing the investigation either in terms of dropping the case or determining the point at which the case is ready for referral for prosecution.

At the conclusion of each investigation the investigator must write a detailed case report and recommendation. If the case is to go forward for prosecution, all documentation must be included (affidavits, photostatic copies, checks, etc.) and the amount of overpayment based on the documentation must be calculated.

Exhibit II-2 presents a summary of BWA case actions for FY74 and 75.

BWA keeps Sanctions informed as to the disposition of cases. However, since BWA has independent authority, it refers cases directly to the appropriate prosecutor. Once a case has been referred, the investigator may continue to develop evidence in line with the prosecutor's guidance.

Program Abuse

Program abuse, such things as overutilization, unnecessary referrals, and quality-of-care issues, which do not constitute fraud, are investigated

Exhibit II-1

The Commonwealth of Massachusetts

Executive Office for Administration and Finance

Bureau of Welfare Auditing

~~141 Milk Street, Suite 450, Boston 02109~~
One Ashburton Place, Room 501, Boston 02108

September 3, 1975

Dear

This bureau is desirous of obtaining information regarding certain practices experienced in the use of transportation services under the Medical Assistance program of the Massachusetts Department of Public Welfare.

We respectfully request your cooperation in this effort by answering the following questions and returning this letter in the enclosed stamped and addressed envelope as soon as possible:

1. Have you or any member of your family used taxi, ambulance or any type of livery service during the month of March 1975?

   Yes ☐ No ☐

2. If so, how often were you transported?

   ☐ Times

3. Identify by name company who furnished transporation services:

   _____
   _____
   _____

Please indicate a telephone number (home and/or business) at which we can contact you in the future.

Home Phone _____

Business Phone _____

Very truly yours,

Paul J. Murphy
Senior Fraudulent Claims Auditor
Bureau of Welfare Auditing

PJM/uw
enc 1

Exhibit II-2

BWA Case Actions FY1974, FY1975

	FY 74					FY 75				
	Quarter				Annual	Quarter				Annual
	1	2	3	4	Total	1	2	3	4	Total
Part I. Allegations and Results of Preliminary Investigations										
A. Allegations awaiting preliminary investigation at beginning of quarter (Item ID, preceding quarter)	—	—	—	—	—	—	—	—	—	—
B. New allegations received or developed during quarter	10	60	11	21	102	10	12	27	13	62
C. Completed preliminary investigations	—	—	—	—	—	—	—	—	—	—
C.1 Allegations dropped	—	—	—	—	—	—	—	—	—	—
C.2 Allegations with evidence sufficient to merit investigations	—	—	—	—	—	—	—	—	—	—
D. Allegations awaiting preliminary investigations at end of quarter (A+B-C)	—	—	—	—	—	—	—	—	—	—
Part II. Complete Investigations and Agency Enforcement Actions										
A. Complete investigations in process at beginning of quarter (Item IIE, preceding quarter)	17	14	67	64	162	59	62	30	24	175
B. Complete investigations begun during quarter 1/	2	57	6	9	74	6	7	8	8	29
C. Cases referred to law enforcement officials	5	2	1	5	13	2	2	1	3	8
D. Complete investigations closed without referral to law enforcement officials and civil referrals	0	2	8	9	19*	1	37	13	0	51*
E. Complete investigations in process at end of quarter (A+B-C-D)	14	67	64	59	204	62	30	24	29	145
Part III. Law Enforcement Actions and Prosecutions										
A. Cases awaiting law enforcement actions or in prosecution at beginning of quarter (Item IIID, preceding quarter)	—	—	—	—	—	—	—	—	—	—
B. Cases referred to law enforcement officials during quarter (Same as item IIC) and civil referrals	5	2	1	5	13	2	2	1	3	8
C. Law enforcement actions completed and cases closed	—	—	—	—	—	—	—	—	—	—
D. Cases awaiting law enforcement action or in prosecution at end of quarter (A+B-C)	—	—	—	—	—	—	—	—	—	—
Part IV. Amounts Recovered During Quarter										
A. Amounts recovered from prosecution	0	0	30	0	30	0	21	0	6	27
B. Total amount recovered from all sources, including prosecutions	0	0	206	229	435	72	62	71	64	270
AMOUNTS IN THOUSANDS OF DOLLARS										

1/ Should agree with IC.2, except in cases where multiple allegations resulted in a single investigation.

*Of these seventy (70), fifty-three (53) were referred for civil process.

by the Office of Sanctions within Provider Review. The Office of Sanctions is aptly named since investigations are conducted with the intent to achieve corrective actions or impose punishments for violations.

For the first time (with the new staffing levels for Provider Review), Sanctions can conduct field investigations as well as desk audits. In general, though, investigations involve desk analyses of profiles and other data to determine patterns of aberrant practices (Sanctions needs only to document that abusive practices exist, unlike BWA which must prove intent for fraud cases). In some cases field visits are necessary to review medical records, verify services, or talk to institutional staff. Although Provider Review staff are primarily involved in the routine reviews described in the detection section of this report, they can be used to a limited extent for Sanction's investigations. Medical consultants are available on a limited basis.

There are various possible outcomes of Sanctions' investigations which may occur at various points in the investigation. These are discussed in Section E of this report.

Although usually only one agency pursues the investigation of a provider, in some cases both Sanctions and BWA are involved. These usually involve cases where the BWA investigation will be lengthy and in the interim the state can be protected by Sanctions investigating the case and imposing suspension as an administrative sanction. In this way DPW is able to prevent the paying of funds it may have to attempt to recover later, possibly unsuccessfully. In these types of cases Sanctions and BWA work very closely so as not to expose BWA's fraud investigation or "contaminate" the fraud case.

Massachusetts has documented or investigated all of the common fraud schemes found in other states, although "Medicaid mills" by the New York definition are not known to exist in the state. Absenteeism or phantom staff, financial manipulation, or manipulation of ownership schemes are outside the purview of DPW and responsibility for these areas rests with the Rate Setting Commission. Since Massachusetts reimburses inpatient facilities on an aggregate rate rather than by individual services, it is impossible for DPW to monitor the practices of inpatient facilities from claims data.

E. Outcomes

1. Administrative Sanctions

Administrative procedures available to DPW range from intent-to-sanction letters to suspensions from the program.

The lowest level of the procedure system is the intent-to-sanction letter. This letter can be used to notify a provider to desist in a particular practice or as the first step toward a formal hearing. If the offense is such that it does not seem to warrant an elaborate investigation and it is the first time a given provider has come to the office's attention, the provider is sent a letter advising him that the particular practice is a violation of regulations and he should correct his activities. He is also advised whom to contact if he has any questions. The provider is then listed on a master register which is checked for prior contacts each time a complaint is received or detected. The provider's case may also be placed in a tickler system for later review. This letter procedure may be used by Sanctions based on very little documentation. It is Sanctions philosophy that the most efficient method for pursuing cases is to discuss the matter with the provider. Therefore, unless there is some specific reason for not doing so, Sanctions prefers to contact the provider through a letter at the most initial stage. This provides a fair opportunity for the majority of providers who have mistakenly interpreted the regulations or billing procedures, or have committed some other abuse unintentionally to correct their practices or ask questions without a major investigation or investment by DPW. The letters also alert providers that review procedures are in effect.

The letter of intent-to-sanction is also the first step in more serious cases. After specifying the problem areas, the letter may go beyond requiring the provider to stop the practice. It may specify restitution amounts calculated as due to the Department or other penalties which may be imposed. The provider may also be advised of the availability of an informal conference with Sanctions staff or be requested to participate in one. If no response is received from the provider, the penalties may be automatically invoked or he may be advised that the Department will suspend payment of his claims until the matter is resolved.

The next step in the process is the informal conference. This conference is chaired by a Sanctions officer who introduces the participant and reviews the issues. The provider may appear with an attorney although they usually do not. In addition to the Sanctions officer, a DPW medical consultant, a Medical Assistance program person, or any other DPW staff involved in the case may be present. At a minimum, two DPW staff members are present to avoid contradictory statements by the provider later. No formal record or procedures are utilized and DPW may not be represented by counsel. Depending on the severity of the case and the importance of the underlying issues, DPW may decide on a case by case basis to have counsel present. After the introductions the provider is given the opportunity to respond to the charges and then a DPW representative, usually the medical consultant, responds. As a result of this conference, the provider may propose an amicable solution, such as making restitution. Frequently the provider requests no publicity as part of his settlement. If no settlement is reached, the provider is informed that the Sanctions officer will write a formal report to the Assistant Commissioner with his findings and recommendations. Upon receipt of the report, the Assistant Commissioner may choose to impose sanctions and so notify the provider. If the case involves strictly medical issues of quality of care or medical necessity rather than a clear violation of program policy and resolution cannot be reached, the case may be referred to the appropriate professional society or PSRO for peer review.

Upon notification of the findings from the informal conference, the provider may request a formal hearing. If this is the case, the Commissioner may choose to grant a stay of sanction pending this hearing. The hearing is held before a hearings officer under the procedures of the state Administrative Procedures Act. This includes:

— swearing in of witnesses

— record of proceedings

— adherence to rules of evidence

— counsel for the defendant at his discretion

— DPW represented by counsel.

Appeal from the formal hearing is to the courts. If a sanction is imposed as a result of the formal hearing, it is usually effective on the date of formal notification to the provider.

Formal hearings are not held frequently since they require a great deal of investment of time and staff by the Department. Informal conferences are held frequently to give the provider a chance to explain his actions and discuss the matter with Sanctions' staff.

Outcomes from informal conferences and formal hearings can include temporary suspension of payments, periods of probation during which claims will be routinely reviewed, and/or findings of restitution due. Recovery will be discussed in a subsequent section of this report. The Department routinely makes discretionary suspensions of payments, although the Department's legal counsel is not convinced that authority for such suspension exists. To date there have been no court tests of the payment suspension authority. Suspensions are used primarily when there is evidence of fraud and the Department wishes to protect itself from paying out funds it may later have to try to recoup. The Department may also temporarily suspend payment pending appeals. Typically, some percentage of the claims are paid so that the provider is not bankrupted, but enough is held to protect the Department. Since suspension has not been court-tested, the Department occasionally does not invoke suspension where a lawsuit is threatened to avoid a costly legal battle and the possibility of losing. The use of suspension is also discretionary in that Sanctions staff considers the impact of suspension on recipients where the provider in question is the only one available or other factors which may argue against suspension.

The only procedures for termination are for providers convicted of larceny of Title XIX funds, who are suspended from the Medicaid program for three years. Providers who are convicted of a felony, which can constitute grounds for revocation of a license to practice in the state, are automatically terminated if their license is revoked.

2. Prosecution

All referrals for prosecution are made by the BWA. Attached as Exhibit II-3 is a list of the provider prosecutions for which there were outcomes in FY74, FY75, and the first quarter of FY76. It should be noted that although convicted of felony fraud, the providers involved generally received suspended sentences and were ordered to pay restitution and/or court costs.

Charges are generally filed under the state larceny statutes which carry felony penalties although perjury and conspiracy charges are also

FISCAL YEAR 1974

~~Name of Provider~~ B.W.A. Case Number	1-00048		
Type of Provider	Pharmacy		
Name of Prosecutor	Assistant Attorney General Harvey Rowe		
Type of Offense	Larceny over $100 Misrepresentation		
Type of Conviction (i.e., forgery, fraud, etc.)	Felony		
Sentence	1 year and 2 years probation		
Was Sentence Suspended?	[X] Yes [ ] No	[ ] Yes [ ] No	[ ] Yes [ ] No
Amount of Restitution	$30,000		
Amount of Penalty			

Exhibit II-3

BWA-Initiated Prosecutions Completed, FY1974-FY1976 First Quarter

FISCAL YEAR 1975

~~Name of Provider~~ B.W.I. Case Number	1-00138	1-00028	1-00259
Type of Provider	Dentist	Pharmacy	Nursing Home
Name of Prosecutor	Assistant District Attorney Joseph Welch	Deputy Ass't Attorney General Edward J. Perlman	Ass't District Attorney Tod Fuccilo
Type of Offense	Larceny over $100 Larceny under $100	Larceny over $100	Larceny over $100 Misrepresentation Rate Setting Commission violation
Type of Conviction (i.e., forgery, fraud, etc.)	Guilty 10/29/74 Both Felony and Misdemeanor	Guilty 10/17/74 Felony	Continued without a finding until 5/20/77
Sentence	1 year hard labor 2 years probation on each offense to run concurrently	2½ years and 2 years probation	$1,000 court costs
Was Sentence Suspended?	[X] Yes [ ] No	[X] Yes [ ] No	[ ] Yes [ ] No
Amount of Restitution	$2,003.00 $2,836.00 to be deducted from bills awaiting payment	$18,895.00	$6,318.06
Amount of Penalty			

Exhibit II-3 (cont)

1976 FISCAL YEAR

~~Name of Provider~~ B.W.A. CASE NUMBER	1-00213	1-00063	1-00068
Type of Provider	Nursing Home	Nursing Home Chain	Nursing Home Chain
Name of Prosecutor	Assistant Attorney General Donald P. Zerendow	Special District Attorney Henry Moran	Assistant Attorney General Donald P. Zerendow
Type of Offense	Larceny over $100	Perjury Attempted larceny Larcenous scheme	Larceny over $100
Type of Conviction (i.e., forgery, fraud, etc.)	Guilty 8/27/75 Felony	Guilty 8/18/75 Perjury and attempted larceny Felonies	Guilty 9/4/75 Felony
Sentence	Two years probation - $750 fine and $2,000 court costs	12-15 years on perjury, 18 mos. on and after attempted larceny	Two years probation $700 fine and $7,000 court costs
Was Sentence Suspended?	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No
Amount of Restitution	$5,915		$38,955
Amount of Penalty		$4,375 total fines	

Exhibit II-3 (cont)

occasionally used. The welfare statute recognizes "misrepresentation" as a misdemeanor. Therefore, the state larceny statute is preferred for use in provider cases.

Cases are usually referred to the District Attorney or handled by the Attorney General's office. Although BWA investigators are continuing to develop relationships with Federal investigatory agencies, to date no cases have gone to the U.S. Attorney. DPW staff feel that the time involved and educational effort required are too burdensome to make Federal prosecution worth pursuing.

3. Recovery

The following mechanisms are used for recovery of funds:

- Voluntary restitution in cases where at some point in the Sanctions process (after a letter or informal conference) the provider voluntarily agrees to repay the Department an agreed upon amount.
- Restitution imposed as an administrative sanction as a result of the findings based on the informal conference or formal hearing.
- Criminal court judgment requiring repayment of funds as part of the sentence or a condition of probation or parole.

In terms of payment mechanisms, DPW prefers to have restitution paid in full at the time of the finding. In cases of extremely large amounts, DPW Provider Review may negotiate a time payment plan although in such situations they prefer only a few installments over a relatively short period of time. Since overpayments essentially constitute an interest-free loan to the provider by the Department, DPW staff feel that they do not owe it to the provider to make repayment easy and that easy repayment provides no incentive for not overbilling the Department.

Only Pilgrim Health Applications has the capability to debit a provider's account and thus collect restitution against future bills. Although this capability exists, the negative incentive value of restitution is largely lost, and this method of collection is not preferred.

Since Provider Review has begun withholding portions of the payments for claims submitted by particular providers under investigation, the

number of actual dollars owed (restitution amount minus withheld payments equals actual dollars owed) should be significantly reduced in the future.

The amount of restitution is calculated based on actual claims rather than projections. DPW and BWA have found this procedure necessary to support the amount in court cases.

In cases in which a criminal case is anticipated, the requirements of that criminal action dictate all other actions. In some cases DPW/Sanctions finds grounds unrelated to the criminal allegations and proceeds through administrative channels to suspend payment to the provider for some or all of his claims. However, this is done only through careful coordination with BWA and the prosecutors.

The Rate Setting Commission acts independently with respect to auditing institutions, but DPW has responsibility for making collections for overpayment as determined through audits.

Neither Sanctions nor BWA reports major problems in collecting restitution as long as the provider remains in the program. The most common obstacle to recoupment is providers leaving the program. The DPW has not been active in the civil recovery area and feels it is more efficient to avoid paying out the funds in the first place. BWA statistics show that approximately 60% of the court-ordered restitution as a result of BWA's fraud cases is collected. Collection is the responsibility of the probation department and the amount of collection depends to a large extent on the emphasis probation places on repayment.

III. RECIPIENT FRAUD AND ABUSE CONTROL PROGRAM

Although Massachusetts has a medically needy program, Medicaid recipient fraud has not been addressed in any significant way by the state. AFDC recipient fraud is a matter for which procedures, controls and penalties exist and is the subject of another report in this series.

- Until the MMIS is implemented, there are essentially no tools for detecting or analyzing data concerning recipients; and
- The manpower constraints in both DPW and BWA have required that the more obvious problems of AFDC recipient and Medicaid provider fraud be addressed.

If complaints are received, DPW or BWA staff do investigate. However, cases of common abuses such as lending Medicaid cards or forgery of cards are essentially nonexistent since such cases are practically impossible to detect based on individual instances.

Areas like third party recoveries are also severely hampered without the MMIS capability.

IV. AGENCY FRAUD AND ABUSE CONTROL PROGRAM

Investigation of allegations of agency or employee fraud is also a responsibility of BWA. However, BWA has no detection responsibility and there are no internal agency audit activities. If a case is referred to BWA, it proceeds with an investigation seeking actionable fraud charges. Staff in both BWA and DPW report that policy is to seek prosecution and employees are not merely allowed to resign without further action taken.

No cases of agency fraud that related to the Medicaid program were cited.

V. PROGRAM ASSESSMENT

A. Introduction

The purpose of this study is to document exemplary or "best practices" currently being used by states in their fraud and abuse control programs that may be of use to other states and to identify "Federal options" for assisting states in this important area. To accomplish these objectives, certain states were selected for site visits as those most likely to contribute positively to the data base and study mission. In visiting the states, it was necessary to review many aspects of the states' Medicaid programs (claims processing, rate setting, etc.) in order to understand the environment in which the fraud and abuse control effort exists. This rather comprehensive review, however, was not in any way intended or structured to provide an evaluation of the state except in the limited "best practice" sense. Also, no state was expected to have a completely exemplary system in all fraud and abuse control functions — prevention, detection, investigation, prosecution, etc. Massachusetts was selected for its administrative sanctions procedures and independent criminal fraud investigation unit. However, it is useful to record each state's comments on its system and our comments on the environment, especially to the extent that some activities may be of use in only that environment or could not be duplicated in a different environment.

B. State Self-Assessment

The recent addition of over 20 staff members to Provider Review activities within DPW makes it difficult for state staff to assess their position. They are very enthusiastic about the new activities they are undertaking and the increased capability to conduct pre-existing functions, but they do not yet have enough experience to assess the total impact of the additional staff.

Provider Review Unit senior staff are very comfortable with their approach and orientation. Since BWA represents the "cop" function relative to criminally fraudulent providers, Provider Review can concentrate on review activities designed to assist providers and improve the program rather than on the potentially punitive aspects of review. At the same time, the Sanctions function exists with sufficient procedural tools to pursue the really abusive providers effectively so that staff is not frustrated by not being able to do anything about such cases. In contrast, BWA is comfortable pursuing actionable fraud cases as an investigatory agency without being constrained by program politics, etc. Both staffs speak highly of this organizational arrangement.

C. Conclusions

Massachusetts does not appear to have any unique characteristics that make the practices used in this state non-exportable. Geographically and demographically it is like many other states in that there is one major city with a concentration of program recipients (Boston) and many rural counties. Neither the types of fraud and program abuses encountered, the bureaucratic structure, economic conditions, nor other characteristics appear to make Massachusetts so atypical as to make the provider fraud and abuse control methods used in Massachusetts not useful in other states.

VI. BEST PRACTICES

A. Introduction

The purpose of this section is to describe those practices employed by the subject state which would appear to be of value to other states. Massachusetts represents a conceptually attractive program with a well-balanced and well-defined approach to the investigation and follow-up of provider fraud

and abuse cases. However, as noted previously in this report, state and Federal officials agree that the existing claims processing system in Massachusetts is unsatisfactory and the MMIS is being implemented. Clearly, the MMIS capability is requisite to any best practice model since the front-end edits and outcome reports significantly enhance the prevention, detection and, to some extent, investigations activities. However, the use to which the outcome reports are put, i.e., investigation and follow-up, are also critical functions. Massachusetts was selected for inclusion in this study because of its record in this area. Once "cases" are detected by the existing rather limited systems in Massachusetts, they are well handled.

The best practice aspects of investigation and follow-up are discussed in the following sections of this report.

B. Organization and Placement of Functions

As discussed in the administration of provider fraud and abuse control section of this report, program abuse and fraud are clearly differentiated in Massachusetts and addressed by separate agencies. Program abuse is the responsibility of the Office of Sanctions/Provider Review Unit within the Medical Assistance Divison of the Department of Public Welfare. Fraud is the responsibility of the independent agency, the Bureau of Welfare Auditing. Both agencies feel that this is an effective and useful organizational arrangement.

The key element in this organization is the separation of responsibilities for criminal fraud investigations and prosecutions from the Medicaid program and, in fact, from the single state agency. There are several reasons which argue for this separation:

-- The independent agency has only one function and one set of objectives against which to be measured. The greater degree of specificity of function, the more likely the function will be well conducted. Large agencies with multiple functions have to prioritize activities and whether justified or not, can obfuscate not conducting messy functions such as fraud investigations.

— The corollary to the previous point is that the independent agency is not tied to the program and program politics.

Therefore, it can conduct its activities largely unhampered by such things as a desire not to offend providers, etc. The reverse is also true in that the program staff who have to work with providers regularly and be concerned that providers continue to participate at acceptable levels are "clean." While the integrity of the program is being maintained through criminal investigations, the program staff is not involved and therefore cannot be blamed by providers.

— Since the independent agency is an investigatory agency, it selects its staff for investigation positions and from the appropriate civil service registers. Criminal investigations require investigation experience rather than program experience. Staff must know how to interview witnesses and defendants, must be able to build a case and document the chain of evidence, must be able to make a presentation suitable for presentation to a prosecuting attorney, must be familiar with courtroom procedures, rules of evidence, etc. Since these types of skills are not normally required by a welfare department, state civil service agencies tend to define investigators as "reviewers" or "analysts" and investigation units within welfare agencies often cannot get access to the appropriate civil service registers.

— When the investigations unit is organizationally independent, it is not susceptible to suspicions of "sweeping cases under the rug" and finds it easier to maintain its credibility and that of the program it serves. As the Director of BWA puts it, "The public must have confidence in the system."

— An investigation agency has unique status within the law enforcement community. Whether or not the agency actually has police powers, it can be identified as a peer among investigation agencies and thus has better access to records, assistance, etc. As an investigation agency it has status with prosecutors.

Massachusetts staff feel strongly that both administrative sanctions and criminal penalties for selected providers are a strong deterrent to fraud and abuse. They also feel that both the organizational independence and quality of the work of BWA contribute significantly to the prevention of fraud in the program. On the other hand, it is also necessary to balance criminal fraud activities with internal program controls for abuse.

The Provider Review Unit of DPW is the other half of the organizational best practice demonstrated by Massachusetts. By stripping out the "cop" function to BWA, the Provider Review Unit is free to work in a constructive and positive manner with providers with administrative sanctions available when required. Provider Review staff can deal with the equally valid issues of misutilization, appropriateness, and quality of care, etc.

While this report intends to make a strong argument for an independent investigatory unit to pursue criminal fraud cases, the reader must understand that that independent agency needs an equal partner in a program abuse control unit. The issues addressed by each are of equal importance and, in fact, the "abuse" cases may in effect save the program more money and have a more beneficial impact than the criminal fraud cases. In any event, criminal cases require enormous resources and a long period of time to develop so there must be a mechanism for handling problem providers in a less costly manner.

C. Characteristics of the Independent Investigatory Agency

There are obviously potential problems relating to independent authority. BWA's professionalism is instructive in this regard. The following are a few characteristics of note:

— Top administrative staff should be administrators, not technicians. As can be noted in many technical fields, extreme competence in a technical area does not necessarily make an individual a good supervisor or administrator. Many sources have suggested that top welfare investigators jobs must be filled with individuals with previous successful experience in management. Top BWA staff are not only competent in conducting investigations but are also good managers. BWA has

management controls and clear organization; the Bureau also has readily available statistics which describe and measure the job it is doing. Reports summarizing BWA activities are prepared as a matter of routine.

— Management control is essential. There must be clear procedures to be followed and regular supervision to monitor work performance and adherence to procedures. The model is that of any police agency. In BWA, all cases are reviewed monthly so that a supervisor is familiar with the status of each case and the caseload and can make suggestions for procedures to be used or tasks to be accomplished. The procedure also means that supervisors can efficiently identify cases that are unproductive and terminate them. In agencies without such regular review procedures, it has later become apparent that investigators were "creaming" the easy cases and ignoring the difficult ones or creating other types of problems.

— The agency must identify with the program it supports. Where feasible, BWA investigators have offices in local welfare agencies. Through co-location they get to know welfare staff and can answer many questions informally without much of the paperwork associated with formal case referrals. Also, recipients often feel more comfortable when participating in an interview about a provider if it is held in the welfare office which is a familiar setting. While co-location is probably most important in regard to recipient fraud cases, it is helpful to investigators to have familiarity with the program in provider fraud cases as well. It is also important for program staff not to perceive the investigators as "cops." All too often the program staff is unwilling to make referrals to a "sheriff's office" if they feel the investigators do not handle the cases with sensitivity and with an understanding of the program. This perception is reduced if both work in the same location and interact daily.

— BWA has no detection responsibility. Therefore, the vast majority of its cases come from DPW referrals. Since BWA

does not detect its own cases, there is no suspicion that it is using its time on witch hunts or selecting inappropriate cases. The DPW staff is better equipped to review profiles and medical reports and, therefore, this arrangement is probably also more efficient than investigators trying to review data and detect cases.

— The agency must have a clear, concrete definition of appropriate cases. BWA uses the term "actionable." While much concern has been focused on high-dollar providers and various apparently fraudulent schemes, BWA concentrates on "actionable" cases, meaning cases which can be successfully prosecuted. BWA feels there is no point in investing an investigator's time if the case cannot be reasonably expected to result in a successful prosecution. At the point of referral, BWA looks at such aspects as jury appeal, apparent intent, types of evidence required, and type of allegation. In the last instance, it is important to determine whether or not some other agency might be more interested in the case or able to handle the case faster or better. Examples include cases involving prescriptions where Federal drug officials might be interested and Federal penalties greater, and cases involving kickback schemes and unreported income which may interest the Internal Revenue Service.

Throughout the development of a case, investigators and supervisors review its "actionable" qualities. This is mandatory since it is more difficult for a prosecutor to refuse a case with clear potential for successful prosecution and the whole rationale for criminal fraud investigations is the deterrent effect of successful prosecutions. BWA feels that investigation, even a trial, without a finding of guilty has little deterrent value. In fact, in a recent case, after 2 weeks of trial, the judge ordered an indefinite continuation with no finding because he had no more time for "white collar" crime on his docket. The Director of BWA felt this case did more harm than if it had never been brought to trial because the

provider got off and apparently proved that providers can beat the system. Unfortunately, BWA had no way to predict that the judge would act in this manner.

This last point is particularly important when contrasted with the parallel agency, the DPW/Office of Sanctions. BWA puts all of its resources into a few "actionable" cases seeking successful prosecutions and findings of guilt. Sanctions always attempts to settle cases at the lowest level with the least investment of resources. This fits with its philosophy that it is a program agency which is not out to "get" the provider. However, the result of having the parallel functions means that with limited resources Massachusetts can handle a high number of actions or cases and still get the deterrent effect of a few expensive successful prosecutions.

D. Administrative Sanctions

The Department of Public Welfare in Massachusetts has a rather fully developed system of armaments in the administrative sanctions area. In fact, the system of procedures is one of the most complete seen in any state.

Since criminal prosecutions are a very limited and costly mechanism which should be reserved for the most flagrant cases, it is essential that a fraud and abuse control program have an array of procedures available to it for the vast majority of cases which are not flagrant, are not prosecutable and do not warrant the degree of resources necessary for a complete fraud investigation.

The most crucial of these procedures is suspension of payments to providers. It is critical that fraud and abuse control staff have suspension authority so that excess amounts of state funds are not paid out when a problem clearly exists. Data from almost all states show that restitution recoveries are significantly less than the projected overpayments. While some steps can be taken to improve recovery mechanisms, it is obviously more cost effective to avoid paying out funds unnecessarily than spending extra dollars to try to recover the money later. The Massachusetts practice is generally to suspend only suspect portions of a provider's billings, not all payments to a suspected provider, while maintaining a dialogue with the provider to resolve the problem.

To have suspension authority, it is necessary to have a system of due process and appeals available to the provider. While the Massachusetts system is neither perfect nor court tested, it does recognize the need for administrative sanctions and has the procedures to impose them.

The following are a few characteristics which make the Massachusetts program exemplary and which should exist in all states fraud and abuse control programs.

- Due to the presence of a sanctions mechanism which is used (particularly suspension), providers take DPW concerns seriously. The result is that problems can usually be solved without escalation and without the use of the more serious sanctions, such as suspension. Therefore, Sanctions staff do not have to do extensive investigations and build cases. A Sanctions letter can be sent out based on very little documentation. This usually generates a response from the provider and a resolution of the problem. In this case, Sanctions has invested very little effort and and has effectively dealt with the provider without having to make real charges or alienate the provider.
- The informal conference mechanism exists to discuss more serious problems than those handled through warning letters and telephone calls. Again, however, the provider knows there is an outcome from the conference including a report of findings to the Commissioner and possible sanctions if an amicable solution is not reached. There are several negative incentives which encourage the provider to reach a settlement: (1) he cannot go to court without having gone to the formal hearing procedure where he incurs the cost of a lawyer, etc.; (2) he could be suspended; (3) formal hearings are part of the public record and he could receive adverse publicity. In another state visited, the fraud and abuse control staff had held informal conferences over several years with a particular provider, but since the provider knew the program had no sanctions authority and was unlikely to take the case to court, he continued the aberrant practices,

having no incentive to cease. Although informal conferences require more preparation than a sanctions letter, they also represent a relatively low level of settlement, and since the procedure is informal, DPW can spare the provider possible bad publicity.

- Formal hearings provide the required legal due process for the provider. This serves as an appeal mechanism for the provider similar to the Fair Hearings mechanism in AFDC for recipients facing adverse action. The existence of such a hearings mechanism appears to be a necessary support for suspension. Formal hearings are necessary for the extreme cases and are probably more valuable for their existence than for their actual use.
- Suspension, as noted previously, is an absolutely essential element of a sanctions process. When used on a discretionary basis within a set of specified criteria, suspension can save a state a great deal of money and provide an incentive for the provider to act expeditiously. If the provider continues to get paid, as he does in many states, there is no incentive for that provider to cooperate or desist in the aberrant practice. Suspension is probably most valuable when used, as in Massachusetts, as a mechanism for speeding settlement of a problem. Except in extreme cases where the provider can reasonably be expected to flagrantly rip off the system again, the value of suspension as a penalty is questionable. In the extreme case, suspension may save the program further investment in investigating the provider. However, in most cases providers are providing needed services to recipients and there is little point in penalizing the recipients through punitive temporary total suspension of the provider. Suspension of payment of some percentage of the provider's claims, as is done in Massachusetts, serves as an incentive for rapid settlement and protects program funds.

— Restitution should be collected as rapidly as possible in lump sums. Since overpayments in effect constitute interest-free loans to the provider, there is no rationale for extending the term of the loan beyond when it is determined payment is due. In fact, restitution is not a penalty per se. The provider is not paying back more money (money from his own pocket) than the overpayments and is probably paying back less. The investment of resources to research claims and calculate overpayments is such that it is almost impossible to calculate every penny of overpayment. In fact, most states are satisfied to only research a particular period of time and not go back through the entire claims history. Therefore, since the provider is paying back the state's own money and is probably paying back less than he actually owes, the state should require payment immediately. Some states have elected to collect restitution through discounting a portion of future claims and debiting the provider's account. Massachusetts does not do this. Such a procedure provides an incentive to the provider to further erroneously inflate his bills and essentially makes it painless for the provider to repay funds he has received through fraud or abuse since it does not harm his cash flow the way a single lump sum payment probably would.

A state fraud and abuse control program needs a complete sanctions capability, including suspension. Having such a mechanism recognizes that there are a wide range of abuses that can be handled at various levels in the process. The availability of serious sanctions like suspension is necessary for serious cases and facilitates settlement of less serious cases. At each level there must be incentives for the provider to reach a settlement in a timely fashion. Serious sanctions activities like formal hearings and suspension should be used sparingly, but must be used if they are to be truly available.

Although we do not accept that all problems are the fault of billing clerks, many problems are based on misunderstandings and misinformation. In

the Massachusetts situation these cases can be handled not only inexpensively but at the appropriate level so that the staff can work toward solutions with the provider in a positive environment.

The effect of this complete sanctions process is

- staff investment commensurate with the size of the problem;
- serious remedies for serious cases;
- expedition of many problems or "cases;"
- demonstration to the provider at the lowest level of infringement that claims are reviewed and action taken, and knowledge by the provider that serious penalties exist;
- a positive working relationship between staff and the vast majority of providers who pose problems but are not flagrantly abusive or fraudulent.

To summarize, the comprehensive and complementary responses of BWA and DPW to Medicaid fraud and abuse at the investigation and follow-up levels constitute a best practice model of functions and authorities from which other states could benefit by emulating.

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